

CITY OF WICHITA GROUP HEALTH INSURANCE PROGRAM

I, _____, carry a family/single (circle one) policy through the City of Wichita's Group Health Insurance program.

I desire to change my participation in the City's Group Plan effective _____

I understand that should I cancel my membership (or coverage for any dependent), I (or my dependent) will never be able to rejoin the City's Group Health Insurance Program.

Signature of Retiree

Retiree's Date of Birth

I desire the following irrevocable change(s):

Cancel membership in the City's Group.

Change coverage from family to single, and cancel coverage for:

Return this form to:

Pension Management
455 N Main, 12th Floor
Wichita, KS 67202
(316) 268-4549